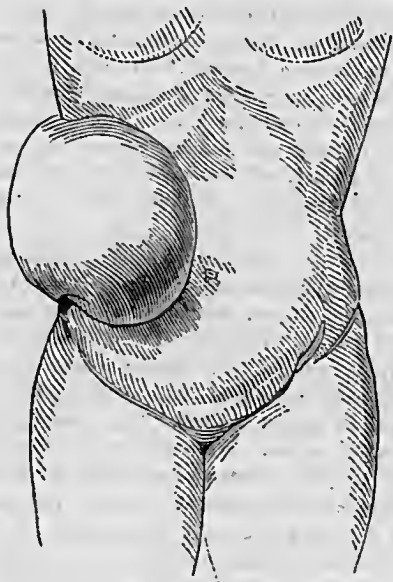


ART. VI.—*Congenital Tumour, composed of numerous cysts*. By WASHINGTON L. ATLEE, M. D. of Lancaster, Pennsylvania. [With three woodcuts.]

March 18, 1842, I was consulted in the case of Henry Gagely, aged four years, for a congenital tumour situated upon the right side. It formed a

Fig. 1.



circle, whose periphery extended into the hypochondriac, lumbar, iliac, hypogastric, umbilical and epigastric regions of the right side, and its centre lay upon the lumbar region a short distance from the angle formed by the boundaries of the umbilical and hypochondriac regions, thus overlaying several of the lower ribs, the abdominal muscles of the right side, and almost encroaching upon the internal abdominal ring. The tumour was yielding, elastic, and owing to its pliability, apparently moveable. The skin covering it

was natural in colour, attenuated in texture, and could not be displaced or pinched up from the sac beneath. Its base could not be moved from its attachments below, evincing firm adhesions throughout its whole extent, and around its entire circumference. Upon shading one-half of the tumour with the hand, and permitting the rays of the sun to fall upon the other, it was semi-transparent, as in hydrocele, indicating aqueous contents, but it differed from hydrocele, inasmuch as percussion produced no perceptible fluctuation.

Three years from the above date, when the child was one year old, the tumour had been punctured by the lancet, three different times, by my brother. A small discharge of serum followed, with very little diminution of the tumour, and a rapid return to its original size.

At the birth of the child the tumour was of the same relative bulk as at

the time I was called in, and had since seemed to have grown with the growth of the child, depending, as it would appear, upon a normal state of nutrition.

The peculiar character of the tumour and its location led me to suspect the possibility of a fistulous connection with the spine, in consequence of which I was very careful in its examination, and particularly so, as some years ago I assisted in the removal of a cyst from the abdominal parietes of a child in which such relations existed, but, previously to the operation, were not suspected. As the case here referred to is one of peculiar interest, and had considerable bearing on the case which I am now reporting, I will digress a moment, while relating a few of its prominent points.

It occupied a large portion of the right side of the abdomen, and was firmly attached by its inferior border to the pubic division of Poupart's ligament and to the external abdominal ring. It was considered as an ordinary encysted tumour, lying between the integument and muscular tissue, and easy of removal. After, however, prosecuting its excision to some extent, the sac happened to be cut into, from which there immediately issued a clear serum, containing flaky matter peculiar to that of lumbar abscess, and at once excited suspicion of spinal communication. Now upon surveying the sac, we discovered a communication, through the external ring, with the inguinal canal, through which a probe was readily passed up towards the spine. The sac, however, was completely dissected out, the wound healed kindly, excepting at the ring, where it retained a fistulous character for some time, and the child ultimately perfectly recovered.

This case, therefore, led me to suspect the possibility of a similar state of things in the case before me, but finding no spinal tenderness or deformity, perceiving no serofulous or cachectic habit of body, but a full, hale and robust constitution, a blooming boy, full of activity and life, the apprehension of spinal disease was scarcely felt, while the successful termination of the one case encouraged me in deciding to free the interesting little fellow of his tumour, even should it prove to be of a similar nature.

Accordingly I made an incision in the direction of the muscular fibres of the obliquus externus extending across the tumour, one inch beyond it, both above and below. The integument was now found to be so intimately incorporated with the cyst, that the greatest difficulty arose in separating them. Indeed, there was no vestige of cellular tissue between them, and consequently it was impossible to carry on the dissection without wounding both the skin and the sac, particularly at the cicatrices formed by the previous punctures. I therefore could not avoid penetrating the very delicate envelope twice, and the cyst several times during the operation. Of course, so soon as the sac was entered there was a copious flow of clear serum, free from flaky particles, and the sac became flaccid, thus increasing the difficulty of the operation. The whole tumour, however, did not collapse,

On the contrary, a firm tumour within the cyst, about three-fourths of the original size, still remained; and upon slitting open the cyst, this tumour was perceived, projecting into its cavity, its exterior surface having been separated from the interior of the sac by the serum which had just escaped. This internal tumour appeared also to be a cyst containing the same kind of fluid, the two cysts being concentric, like the laminae of an onion. After very great difficulty, I came down to the base of the tumour, and here, where the integument was reflected upon the tumour from the parietes of the abdomen, was to be discovered the only traces of cellular membrane, and this was very short and dense. Now proceeding to dissect up the base of the tumour from the sheath of the rectus muscle, its attachments were found to be equally strong. Owing to the condensation, I might say obliteration, of the intervening tissue, I had not prosecuted this part of the dissection very far before I penetrated another cavity, and gave issue to another copious discharge of serum. The whole body of the tumour now collapsed, and I discovered that I had punctured the sac of the internal tumour through its base. After freeing the tumour from the fascia, it was found to be as closely bound down to the fibres of the obliquus externus, portions of which were removed with the cyst, in order to insure the entire extirpation of the sac. A large portion of the muscle, extending from its serratures upon the ribs down almost to Poupart's ligament, was now exposed. Carrying on the dissection of the base, I finally freed its posterior border from under the latissimus dorsi, whose anterior edge presented into the cavity now left by the extirpation of the cyst. A few small arterial branches were cut, requiring no ligature. The surfaces of the wound were then sponged, and carefully examined, and no portions of the sac being discovered, the wound was dressed as usual, retaining the skin in close apposition with the muscular surface by means of a compress and roller.

In consequence of the extent, the firm adhesions, and the character of the tumour, the whole operation was exceedingly difficult and tedious, occupying three quarters of an hour for its completion.

20th. The wound was dressed, and appeared to have been healed by the first intention. Continued firm compression.

28th. Continued to do well until to-day. Discovered that a small collection of serum had taken place, and that there was a tendency to sloughing in the attenuated skin. This was attributed to the want of support to the parts by the bandage, which had become considerably relaxed during the last 24 hours.

April 3d. Discharge of serum and sloughing of small portions of integument; ordered emollient poultices.

5th. A considerable amount of serum collected, which was discharged by penetrating through the gangrenous skin with a lancet; continued the compress and roller.

7th. More serum collected, which escaped upon the removal of the dressings; introduced into the cavity a tent of lint.

8th. No collection of serum, although compress and roller were wet.

10th. No collection and no effusion.

13th. Adhesions going on.

20th. The wound perfectly healed.

May 20th. Examined the wound, remains well, and has continued so ever since.

Upon slitting open the sacs—two of which had constituted the main body of the tumour—their internal surfaces were observed to be lined by a shining membrane, and by strong fibrous bands, resembling tendinous or aponeurotic tissue, crossing each other in various directions. The appearance resembled, in some degree, the tendinous structure of the internal faces of the ventricles of the heart. Numerous other and smaller cells were mingled with these, particularly on the right side of the tumour, and surrounding its base between the two cysts. Several of these small cysts were still full of a pinkish coloured fluid, and bulged into the cavity of the largest sac, taking the appearance of hydatidigenous bodies. Others communicated with each other through small canals, and all were bound together by fibro-cellular interstitial substance.

Fig. 2.

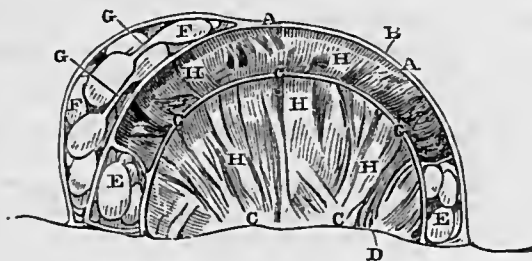


Fig. 2, represents a perpendicular section of the tumour.

A, A.—The external coat of the tumour.

B.—The point at which it was first punctured in the extirpation.

C, C, C, C, C.—The internal coat of the tumour.

D.—The point at which it was punctured in the extirpation. The space between the two coats, and the space within the internal coat were filled with serum.

E, E.—Small cysts between the two coats, surrounding the base of the internal one.

F, F.—Small cysts external to and riding upon the right side of the external envelope.

G, G.—Canals of communication between the small cysts.

H, H, H, H, H.—Aponeurotic bands lining the large cysts.

Fig. 3.

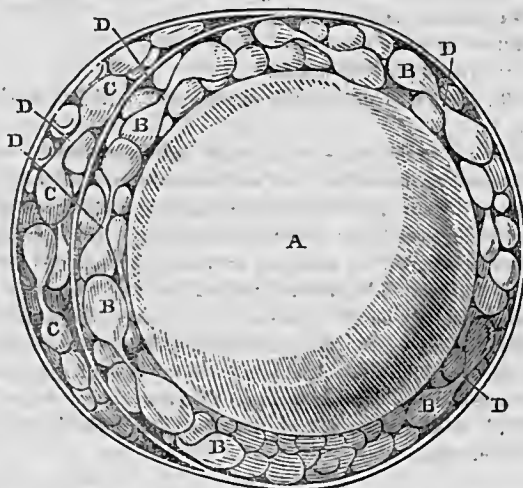


Fig. 3, represents an anterior view of the tumour with the external coat removed within a short distance from its base.

A.—The internal cyst entire, forming the tumour which projected into the cavity of the external cyst, and constituted the body of the tumour at the time the external cyst collapsed.

B, B, B, B, B.—Small cysts or vesicles between the two cysts, surrounding the base of the internal one.

C, C, C.—Small cysts or vesicles outside of the external cyst.

D, D, D, D, D.—Canals of communication between the small cysts.

LANCASTER, Penna. Sept. 25th, 1843.

ART. VII.—*Notices of the History and Properties of Sulphate of Potash.*

By T. ROMEYN BECK, M. D.

SULPHATE of potash (vitriolated tartar) was known to the chemists of the middle ages, and according to Professor Christison (*Dispensatory*, p. 743), the process for making it was first discovered by Crollius, about the middle of the seventeenth century. "It was known," says Dr. A. T. Thomson, "at a very early period, under a great variety of names, as for instance,